

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☒ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

March 14, 1996

ALL-COUNTY LETTER NO. 96-09

TO: ALL COUNTY GAIN COORDINATORS
ALL COUNTY WELFARE DIRECTORS

SUBJECT: WORKERS' COMPENSATION INSURANCE COVERAGE FOR
PARTICIPANTS IN ALTERNATIVE WORK EXPERIENCE (AWEX) AND
PREEMPLOYMENT PREPARATION (PREP) ASSIGNMENTS.

REFERENCES: MPP SECTIONS: 42-730.3 AND 42-740.15

Since April 1, 1988, individuals in the Greater Avenues for Independence (GAIN) program participating in a PREP assignment have been covered for workers' compensation insurance as required by the Welfare and Institutions Code Section 11328 (6) and 11328.1 (B) and Manual of Policies and Procedures Section 42-740.15. This coverage was extended during FY 1994-95, to individuals participating in the Unemployed Parent Work Experience (UWEX) assignments. Effective January 1, 1996, the UWEX is now known as Alternative Work Experience (AWEX) and has been expanded to include all AFDC recipients who are participants in the GAIN Program.

The California Department of Social Services (CDSS) contracts with the State Compensation Insurance Fund (SCIF) to perform adjusting services and to administer the workers' compensation benefits to GAIN participants assigned to work experience activities (PREP, AWEX). The California Department of General Services, Office of Risk and Insurance Management manages the workers' compensation program for CDSS.

Since the original contract with SCIF was put into effect, there have been numerous changes in the workers' compensation laws and in the manner in which SCIF adjusts claims for participants in the GAIN PREP program. These recent changes have also impacted the AWEX program. This letter supersedes All County Letter (ACL) No. 88-50, May 31, 1988.

Effective immediately, if any participant assigned to a work experience activity is injured while performing his or her assignment, the county must submit any medical reports, bills, and a Reporting Packet to:

State Compensation Insurance Fund
Sacramento State Contract Office
P. O. Box 659011
Sacramento, CA 95865-9011

The Reporting Packet must contain: 1) Form SCIF 3367, Employer's Report of Occupational Injury or Illness; 2) Form SCIF 3301, Employee's Claim for Workers' Compensation; and 3) Verification of GAIN PREP/AWEX status and receipt of an AFDC grant for 12 months or less (time on aid does not affect coverage) prior to date of injury. These submittals must be in accordance with the following guidelines:

1. Information on all work-related injuries of PREP/AWEX participants must be submitted to the SCIF Sacramento State Contract Office on both Forms SCIF 3367 and SCIF 3301.

The claim forms are to be completed by a designated individual in the public agency, non-profit organization, or private for profit organization worksite where the participant is performing the work experience activities. The claim forms must be completed within 24 hours of the occurrence or knowledge of the occurrence of the injury.

All information requested on these forms is essential to the proper handling of the claim. The information must be complete, accurate, and contain the worksite supervisor's signature. The worksite supervisor's signature is not an admission of liability.

It is the County Welfare Department's (CWD) responsibility to ensure that the Reporting Packet is promptly and correctly completed. If the location of the assignment is other than the CWD, a copy of the claim must be forwarded simultaneously to the CWD.

2. The Form SCIF 3367 is very similar, if not identical, to the forms that all employers, including counties, fill out when one of their salaried employees is injured while working. The questions on this form are self-explanatory with the following exceptions:

- | | |
|-------------------|---|
| Question 1 | This should be the name of the agency where the participant is assigned, preceded by the acronym for the program, "GAIN PREP" or "GAIN AWEX"; |
| Question 1A | A constant for all claims; CONTRG-O; |
| Question 2, 2A, 3 | These should reflect data relating to the public agency or non-profit organization where the participant is assigned; |
| Question 3A | Enter the three digit County Code where GAIN PREP/AWEX participant is assigned; |
| Question 5 | Not applicable; |

Question 14B Not applicable;

Question 15 Give monthly grant amount (include printout of grant amount for the past 12 months); and

Question 36 Important to be completed with phone number.

3. Along with the Forms SCIF 3367 and 3301, the CWD must also submit as part of the Reporting Package, a verification of the GAIN PREP/AWEX employment assignment (e.g., employment contract) and the amount of maximum aid. Be sure to include grant information for the previous 12 months. This information is used to determine correct disability amounts. Please note, effective January 1, 1996, temporary workers' compensation is to be treated as earned income per ACL No. 95-69, dated November 16, 1995.
4. If a PREP or AWEX participant is killed or sustains a serious injury, the designated responsible individual in the agency should immediately call the SCIF Sacramento State Contract Office at (916) 567-7500. If the agency is other than the CWD, the responsible individual must call the CWD immediately, as well.

The SCIF Sacramento State Contract claims adjusters assigned to handle GAIN PREP/AWEX claims are:

Eleisa Simmons (916) 567-7617

Kathleen Kottman (916) 567-7612

These adjusters will be contacting the GAIN County Coordinators for further information on individual cases. It is the responsibility of the GAIN Coordinators to provide all necessary information. Cooperating with these adjusters and providing requested information is not considered a violation of confidentiality since SCIF is under contract with CDSS to administer these benefits and is acting on behalf of the CDSS.

SCIF adjusters may ask questions which include, but are not limited to, the following:

- Return to work dates;
- Length of GAIN PREP/AWEX assignments;
- Availability of alternative/modified work;
- Background information;
- Medical information; or
- Grant information.

If you have any questions related to completing the forms or administration of benefits by SCIF, please contact David B. Hall in the State Department of General Services, Office of Risk Insurance Management, at (916) 323-2749. If you have any questions regarding the information in this All-County Letter, you may contact your GAIN Operations Analyst at (916) 657-3403.

A handwritten signature in black ink that reads "Bruce Wagstaff". The signature is written in a cursive, slightly slanted style.

BRUCE WAGSTAFF
Deputy Director
Welfare Programs Division

Attachments

State of California

Please complete

locate (type, if possible). Mail original and one copy to:

EMPLOYER'S REPORT
OF OCCUPATIONAL
INJURY OR ILLNESSSTATE COMPENSATION INSURANCE FUND
CONTRACT ADMINISTRATION

SEE REVERSE SIDE FOR ADJUSTING OFFICE ADDRESS

OSHA
Case No.☐ Fatality

NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER	1. FIRM NAME		DIVISION		1A. CONTRACT NUMBER	DO NOT USE THIS COLUMN	
	2. MAILING ADDRESS (Number and Street, City, ZIP)				2A. PHONE NUMBER		
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)				3A. LOCATION CODE		
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.				5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.		
EMPLOYEE	6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____					Occupation	
	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER		9. DATE OF BIRTH (mm/dd/yy)		Sex
	10. HOME ADDRESS (Number and Street, City, ZIP)				10A. PHONE NUMBER		Age
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		12. OCCUPATION (Regular job title—No initials, abbreviations or numbers)		13. DATE OF HIRE (mm/dd/yy)		Daily hours
INJURY OR ILLNESS	14. EMPLOYEE USUALLY WORKS hours per day _____ days per week _____ total weekly hours _____		14A. EMPLOYMENT STATUS (See instructions in 14A continued below.) regular full-time _____ part-time _____ temporary _____ seasonal _____		14B. Under what class code of your policy were wages assigned?	Days per week	
	15. GROSS WAGES/SALARY \$ _____ per _____		16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO			Weekly hours	
	17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)	18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.		20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	Weekly wage	
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm/dd/yy)	23. DATE RETURNED TO WORK (mm/dd/yy)	24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	County	
ILLNESS	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	Nature of injury	
	28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)					Part of body	
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.						
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		30A. COUNTY	30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			Source
ILLNESS	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.		32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			Event	
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.					Sec. Source	
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.					Extent of injury	
	35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.						
ILLNESS	36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)				36A. PHONE NUMBER	Extent of injury	
	37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)				37A. PHONE NUMBER		
	38. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO		39. WAS INJURED AN EXECUTIVE OFFICER OR A PARTNER? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	14A. EMPLOYMENT STATUS CONT. (Check current status of employment, not status at time of injury.) ____ UNEMPLOYED ____ ON STRIKE ____ DISABLED ____ RETIRED ____ LAID OFF ____ OTHER						
Completed by (type or print)		Signature		Title	Date		

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

☐ P.O. Box 4973
Eureka, CA 95502-4973

☐ P.O. Box 91-1112 (State Contract)
Commerce, CA 90091-1112

☐ P.O. Box 659011 (State Contract)
Sacramento, CA 95865-9011



**EMPLOYEE'S CLAIM FOR
WORKERS' COMPENSATION BENEFITS**

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the Information and Assistance Unit of the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of felony.

**RECLAMO DEL EMPLEADO PARA BENEFICIOS
DE COMPENSACION DEL TRABAJADOR**

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la Unidad de Información y Asistencia de la División de Compensación del Trabajador llamando al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que con conocimiento haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee: Empleado:

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of injury. *Hora en que ocurrió* _____ a.m. _____ p.m.
5. Address/place where injury happened. *Dirección/lugar donde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describe la lesión y la parte del cuerpo afectada.* _____
7. Signature of employee. *Firma del empleado.* _____

Employer - complete this section and give the employee a copy immediately as a receipt.

Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

8. Name of employer. *Nombre del empleador.* _____
Address. *Dirección.* _____
9. Policy #. *Poliza #.* _____ 10. Employee Soc Sec #. *Seguro Social del Empleado #.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición completada al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* **STATE COMPENSATION INSURANCE FUND** _____
15. Signature of employer representative. *Firma del representante del empleador.* _____
16. Title. *Título.* _____ 17. Date. *Fecha.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

**STATE
COMPENSATION
INSURANCE
FUND**

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros y empleado, dependiente o representante que haya presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma completa del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

WORKERS' COMPENSATION BENEFITS

Medical Care. Your employer will arrange for medical care, and all costs are paid directly by your employer's insurance company, so you should never see a bill. All medical treatment to cure or relieve your condition will be provided without a deductible or dollar limit.

Payment for Lost Wages. If you are temporarily disabled by a job injury or illness, you will receive tax-free income until your doctor says you are able to return to work. Temporary disability payments are two-thirds of your average weekly pay, up to a maximum set by state law. (Some employees are entitled to receive full salary in lieu of temporary disability payments.) Payments are not made for the first three days you are disabled unless you are hospitalized as an inpatient or unable to work for more than 14 days.

Rehabilitation. If the injury or illness prevents you from returning to the same job, you may qualify for vocational rehabilitation benefits, with all costs paid by your employer's insurance company.

Payment for Permanent Disability. If the injury or illness results in a permanent handicap, permanent disability payments will be paid after recovery.

Death Benefits. If the injury results in death, a benefit will be paid to surviving dependents.

If you need assistance completing this form, or if you have questions regarding your benefits, please contact the Information and Assistance Unit of the Division of Workers' Compensation by calling toll free, 1-800-736-7401. You also have the right to consult an attorney.

Disclosure of Medical Records. Your medical records, including medical records not related to this claim, can be subject to disclosure in a proceeding before the Workers' Compensation Appeals Board or once a claim has been filed. If you do not agree to voluntarily release medical records, they can be subpoenaed and ordered to be produced. In proceedings before a workers' compensation judge, certain medical records can be "sealed" (kept confidential) upon request.

BENEFICIOS DE COMPENSACION AL TRABAJADOR

Cuidado Médico. Su empleador hará los arreglos para el cuidado médico, todos los costos son pagados directamente por la compañía de seguros de su empleador, así Ud. nunca tendrá que ver una cuenta. Todos los tratamientos médicos para curarlo o aliviar su condición serán proporcionados sin deducible o cantidad de límite de dólares.

Pagos por Pérdida de Sueldos. Si Ud. está temporalmente incapacitado por una lesión o enfermedad causada en su trabajo, Ud. recibirá ingresos libres de impuestos hasta que su médico diga que Ud. puede volver a trabajar. Los pagos por incapacidad temporal son dos tercios del promedio de su pago semanal, hasta un máximo asignado por la ley del estado. (Algunos empleados tienen derecho a recibir salario completo en vez de recibir pagos por incapacidad temporal.) No se efectúa pago por los tres primeros días que Ud. está incapacitado a menos que Ud. está hospitalizado como paciente interno o incapacitado para trabajar por más de 14 días.

Rehabilitación. Si la lesión o enfermedad le impide a Ud. volver al mismo trabajo, puede ser que Ud. califique para los beneficios de rehabilitación vocacional, con todos los costos pagados por la compañía de seguros de su empleador.

Pagos por Incapacidad Permanente. Si los resultados de la lesión o enfermedad producen un impedimento o incapacidad permanente, se efectuarán pagos de la recuperación.

Beneficios de Muerte. Si la lesión resulta en muerte, el beneficio será pagado a los dependientes sobrevivientes.

Si Ud. necesita ayuda para completar esta forma, o si Ud. tiene preguntas relacionadas con sus beneficios, por favor póngase en contacto con la Unidad de Información y Asistencia de la División de Compensación del Trabajador llamando gratis al 1-800-736-7401. También tiene Ud. el derecho a consultar a un abogado.

Revelación de Expedientes Médicos. Sus expedientes médicos, incluyendo los expedientes médicos no relacionados a esta petición, pueden estar sujetos a ser revelados o descubiertos en un proceso legal ante el Directorio de Apelaciones de Compensaciones al Trabajador o una vez que la petición haya sido archivada. Si Ud. no está de acuerdo a entregar voluntariamente los expedientes médicos, pueden ser ordenados en un comparendo (orden judicial). En un proceso legal ante el juez de compensaciones al trabajador, ciertos expedientes médicos pueden ser "cerrados" (mantenidos confidencial) si se solicita.